Wisconsin Medicaid Companion Document to HIPAA Implementation Guide:
837 Dental

Companion Document Audience

Companion documents are intended for information technology and/or systems staff who will be coding billing systems or software for compliance with the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Purpose of Companion Documents

The information contained in this companion document applies to Wisconsin Medicaid and BadgerCare, although the companion document only refers to Wisconsin Medicaid.

The companion documents are designed to be used with HIPAA Implementation Guides. Companion documents provide Wisconsin Medicaid-specific information that details the way to create HIPAA transactions for Wisconsin Medicaid and explains how Wisconsin Medicaid creates HIPAA transactions. Companion documents clarify the HIPAA-designated standards usage but are not intended to supercede them. The purpose of companion documents is to provide trading partners with a guide to communicate the Wisconsin Medicaid-specific information required to successfully exchange transactions electronically with Wisconsin Medicaid.

Wisconsin Medicaid will accept and process any HIPAA-compliant transaction. However, a compliant transaction that doesn't contain Wisconsin Medicaid-specific information, though processed, may be denied for payment. For example, a compliant 837 claim created without a Wisconsin Medicaid recipient identification number will be processed by Wisconsin Medicaid, but will be denied payment.

Companion documents highlight the data elements significant for Wisconsin Medicaid. For transactions created by Wisconsin Medicaid, companion documents explain how certain data elements are processed. Please refer to the companion document first if there is a question about how Wisconsin Medicaid processes a HIPAA transaction. For further information, contact the Division of Health Care Financing (DHCF) Electronic Data Interchange (EDI) Department at (608) 221-9036.

X12 837 Health Care Claim: Dental

Loop	Element	Name	Instructions
	ISA	Interchange control header	The ISA is a fixed-length record with fixed-length elements. Note: Deviating from the standard's ISA element sizes will cause the interchange to be rejected.
	ISA05	Interchange ID (sender) qualifier	Enter the value "ZZ," mutually defined.
	ISA06	Interchange sender ID	Enter the eight-digit numeric vendor number assigned by Wisconsin Medicaid.
	ISA07	Interchange ID (receiver) qualifier	Enter the value "ZZ," mutually defined.
	ISA08	Interchange receiver ID	Enter "WISC_DHFS".
	GS02	Application sender's code	Enter the same value as ISA06, the eight-digit numeric vendor number assigned by Wisconsin Medicaid.
	GS03	Application receiver's code	Enter "WISC_TXIX" for Wisconsin Medicaid.
	GS08	Version / release / industry identifier code	Enter the value "004010X097A1," the HIPAA-mandated implementation guide release for this transaction. Note: This code represents the HIPAA implementation guide with the most recent addenda changes. Using an earlier guide, without the most recent addenda changes, does not comply with the HIPAA rule and will cause the transaction to be rejected.

Loop	Element	Name	Instructions
	BHT03	Originator application transaction identifier	Make this identifier unique to a single transaction (ST to SE envelope). Repeating a value will cause the transaction to be rejected. Wisconsin Medicaid recommends using a value with an easily identifiable pattern to aid research (e.g., "ANY_GROUP_PRACTICE_20031016" or "ANY GROUP PRACTICE #00001").
	REF02	Transmission type code	Enter the value "004010X097DA1" to indicate dental claim. Note: This version includes the addenda.
1000A	NM109	Submitter primary identification number	Enter the same value as ISA06, the eight-digit numeric vendor number assigned by Wisconsin Medicaid. Note: A new vendor number will be issued for submitting HIPAA transactions. This number will replace the submitter's current vendor number.
1000B	NM101	Entity identifier code	Enter the value "40" for receiver.
1000B	NM102	Entity type qualifier	Enter the value "2" for non-person entity.
1000B	NM103	Receiver name	Enter "Wisconsin Medicaid" to indicate the claims are being sent to Wisconsin Medicaid.
1000B	NM108	Identification code qualifier	Enter the value "46" for electronic transmitter identification number.
1000B	NM109	Identification code or receiver primary identifier	Enter the same value as GS03, "WISC_TXIX" for Wisconsin Medicaid.
2000A	PRV01	Provider code	Enter the value "BI" to indicate the rendering/performing provider is the same entity as the billing provider, or enter the value "PT" to indicate the rendering/performing provider is the same entity as the pay-to provider.

Loop	Element	Name	Instructions
2010AA	REF	Billing provider secondary identification	Include this segment if the provider entered in loop 2010AA is the provider certified by Wisconsin Medicaid to submit claims. Note: Wisconsin Medicaid requires all claims be submitted with the Wisconsin Medicaid billing provider number.
2010AA	REF01	Reference identification qualifier	Enter the value "1D" for the Medicaid provider number.
2010AA	REF02	Billing provider identifier	Enter the eight-digit billing provider number assigned by Wisconsin Medicaid.
2010AB	NM1	Pay-to provider name	Note: The information in this segment will not be used to determine where to send the provider Remittance and Status (R/S) Report and/or 835 Health Care Claim Payment/Advice. The R/S Report and/or the 835 will be sent to the entity established during the provider certification process.
2010BA	NM1	Subscriber name	Enter information about the subscriber/recipient in this loop.
2010BA	NM102	Entity type qualifier	Enter the value "1" to indicate the subscriber is a person.
2010BA	NM103	Subscriber last name	Enter the recipient's last name. Note: Use the Eligibility Verification System (EVS) to obtain the correct spelling of the recipient's name. If the name or spelling of the name on the Medicaid identification card and the EVS do not match, use the spelling from the EVS.
2010BA	NM104	Subscriber first name	Enter the recipient's first name. Note: Use the EVS to obtain the correct spelling of the recipient's name. If the name or spelling of the name on the Medicaid identification card and the EVS do not match, use the spelling from the EVS.
2010BA	NM108	Identification code qualifier	Enter the value "MI" for the member identification number.

Loop	Element	Name	Instructions
2010BA	NM109	Subscriber primary identifier	Enter the recipient's 10-digit Medicaid identification number. Note: Do not enter any other numbers or letters. Use the Medicaid identification card or EVS to obtain the correct identification number.
2300	CLM01	Patient account number	Note: Wisconsin Medicaid will process up to 20 characters.
2300	CLM02	Total claim charge amount	Enter the total billed amount for the entire claim. Note: Wisconsin Medicaid will process claims submitted with a negative total billed amount as if the provider submitted a zero total billed amount.
2300	CLM05-1	Facility code value	Enter the place of service (POS) code. Note: The national two-digit codes replace the one-digit POS codes that were locally defined by Wisconsin Medicaid. This is an external code set of the 837. See the CMS Web site, cms.hhs.gov/states/posdata.pdf, for appropriate value selections.

Loop	Element	Name	Instructions
2300	CLM05-3	Claim frequency code	The third digit of the type of bill, as defined by the National Uniform Billing Committee (NUBC), is the frequency. Use the claim frequency code to indicate if the claim is being submitted for the first time or if it is a replacement/void of a previously adjudicated claim and paid claim. • Enter the value "1" to indicate it is the first time a claim is submitted to Wisconsin Medicaid. • Enter the value "7" to indicate this claim is replacing a previously submitted and adjudicated claim. Wisconsin Medicaid will null and void the previously submitted claim and completely replace it with this corrected claim. • Enter the value "8" to indicate Wisconsin Medicaid should recoup the previously submitted claim in its entirety. Note: The use of values "7" and "8" will result in the previously submitted claim being adjusted. Include the ICN from the previously submitted claim in the original reference number segment in loop 2300. Any adjustment request without the previous ICN will be processed as if the provider submitted a "1" in this element. If the previously submitted claim was returned with multiple ICNs from Wisconsin Medicaid, the provider must take that into account when using the values "7" and "8". When using the value "7", the claim must contain the exact service lines that were previously processed for the ICN being adjusted, in addition to any new service lines. If multiple service lines need to be replaced and they are on different ICNs, an adjustment must be submitted for each ICN. When using the value of "8" an adjustment must be submitted for each ICN.

Loop	Element	Name	Instructions
2300 (cont.)	CLM05-3	Claim frequency code	Electronic adjustments are subject to the same requirements as paper adjustments and therefore may result in a letter to the provider if the requirements are not met. Do not use adjustment values if reconsideration of the original payment is needed. All requests for reconsideration should be submitted on paper with supporting documentation. The claim frequency code was switched to an external code source during the addenda process. See the NUBC manual or Web site, http://www.nubc.org/FL4forWeb2_RO.pdf, for additional information on value selections.
2300	CLM19	Claim submission reason code	Note: Wisconsin Medicaid does not support predetermination of benefits.
2300	DTP01	Date/time qualifier	Enter the value "472" for service date.
2300	DTP02	Date time period format qualifier	Enter the value "D8" if all the services being billed on the claim were performed on the same date, or "RD8" if the services being billed on the claim were not performed on the same date.
2300	DTP03	Service date	If "D8" was used in the previous element, this is the date on which all the services were performed. If "RD8" was used, this is the date period that covers all the services on the claim.
2300	PWK	Claim supplemental information	Note: Prior to the implementation of the 275 Additional Information to Support a HealthCare Claim or Encounter transaction, Wisconsin Medicaid will not be matching attachments to electronic claims. Submit all claims requiring attachments on paper.
2300	REF02	Service authorization exception code	Enter the value "03" to indicate all services on the claim are the result of emergency care. Note: If not all services were the result of emergency care, submit multiple claims.

Loop	Element	Name	Instructions
2300	REF	Original reference number	Include this segment when requesting an electronic adjustment. (A value of "7" or "8" in CLM05-3 indicates that an adjustment is being requested.) Note: If this segment is not included, the claim will be processed as a new claim and not as an adjustment regardless of the value in CLM05-3.
2300	REF01	Reference identification qualifier	Enter the value "F8" for original ICN.
2300	REF02	Claim original reference number	Enter the most recent ICN assigned by Wisconsin Medicaid.
2300	REF	Prior authorization or referral number	Enter the prior authorization (PA) number. Note: Wisconsin Medicaid will use the first PA number submitted at the claim level (loop 2300) unless overridden in the service line segment (loop 2400). Wisconsin Medicaid does not use referral numbers in the adjudication of claims.
2300	REF01	Reference identification qualifier	Enter the value "G1" for PA.
2300	REF02	Referral number	Enter Medicaid's seven-digit PA number.
2310B	REF	Rendering provider secondary identification	Enter the rendering(performing) provider Medicaid identification number in this segment if the performing provider is Medicaid certified and different then the Wisconsin Medicaid billing provider.
2310B	REF01	Reference identification qualifier	Enter the value "1D" for Medicaid number.
2310B	REF02	Rendering provider secondary identifier	Enter the eight-digit provider number assigned by Wisconsin Medicaid.

Loop	Element	Name	Instructions
2320	SBR	Other subscriber information	Include this loop when the claim will be processed by multiple payers.
2320	CAS	Claim level adjustments	Include this segment when another payer has made payment at the claim level. If the other payer returned an 835 HealthCare Claim Payment/Advice, the CAS segment from the 835 should be copied to this CAS.

Note: Wisconsin Medicaid will use the information in the CAS segment in place of the "other insurance indicator" and "Medicare disclaimer code" submitted prior to HIPAA.

If this iteration of loop 2320 contains information from a Medicare payer, Wisconsin Medicaid will also look for Medicare's coinsurance, copayment and deductible in this segment. |
2320	AMT	Coordination of benefits (COB) payer paid amount	This segment contains the amount paid on this claim for the provider within this 2320 loop.
2320	AMT01	Amount qualifier code	Enter the value "D" for payer amount paid.
2320	AMT02	Payer paid amount	Enter the amount paid on this claim for the provider within this 2320 loop.
2320	AMT	Coordination of benefits (COB) allowed amount	Enter how much the other payer allowed for the claim in this segment.
2320	AMT01	Amount qualifier code	Enter the value "B6" for allowed amount.
2320	AMT02	Allowed amount	Enter the other payer's allowed amount.

Loop	Element	Name	Instructions
2330B	DTP	Claim paid date	Enter the date Medicare paid the claim in this segment if the recipient is a dual-entitlee and loop 2320 contains information about the Medicare payer. Note: This information is either included here or in loop 2430.
2330B	DTP01	Date/time qualifier	Enter the value "573" for date claim paid.
2330B	DTP02	Date time period format qualifier	Enter "D8" for format ccyymmdd.
2330B	DTP03	Adjudication or payment date	Enter Medicare's claim paid date.
2400	SV301-1	Product or service ID qualifier	Enter the value "AD" for American Dental Association (ADA) codes.
2400	SV301-2	Procedure code	Enter the CDT procedure code published by the ADA for the services performed.
2400	SV301-3	Procedure code modifier 1	Note: With the implementation of HIPAA, only ADA-approved modifiers can be submitted on the dental 837. Wisconsin Medicaid will not use any ADA modifiers for the adjudication of claims.
2400	SV301-4	Procedure code modifier 2	Note: With the implementation of HIPAA, only ADA-approved modifiers can be submitted on the dental 837. Wisconsin Medicaid will not use any ADA modifiers for the adjudication of claims.
2400	SV301-5	Procedure code modifier 3	Note: With the implementation of HIPAA, only ADA-approved modifiers can be submitted on the dental 837. Wisconsin Medicaid will not use any ADA modifiers for the adjudication of claims.
2400	SV301-6	Procedure code modifier 4	Note: With the implementation of HIPAA, only ADA-approved modifiers can be submitted on the dental 837. Wisconsin Medicaid will not use any ADA modifiers for the adjudication of claims.

Loop	Element	Name	Instructions
2400	SV302	Line charge amount	Enter the billed amount for each service line procedure. Note: Wisconsin Medicaid will process claims submitted with a negative service line billed amount as if the provider submitted a zero service line billed amount.
2400	SV303	Facility type code (place of service)	Enter the POS code. Note: The national two-digit codes replace the one-digit POS codes that were locally defined by Wisconsin Medicaid. The facility type code is an external code set of the 837. See the CMS Web site, cms.hhs.gov/states/posdata.pdf, for appropriate value selections.
2400	SV304	Oral cavity designation	Enter the area of the oral cavity in which the service was performed.
2400	SV306	Procedure count quantity	Enter the quantity or number of units for the services provided.
2400	TOO	Tooth information	Note: The 4010 version of the 835 Health Care Claim Payment/Advice does not allow for the tooth number to be returned. If the tooth number is necessary for your system's reconciliation, create separate service lines for each tooth and use a unique value in the line item control number segment for each service line. This segment can repeat 32 times per procedure billed. If multiple tooth numbers are submitted on one service line, Wisconsin Medicaid will create one service line for each tooth number to adjudicate the claim.
2400	TOO01	Code list qualifier code	Enter the value "IP" for the national standard tooth-numbering system.
2400	TOO02	Tooth code	Enter the tooth number for which the service was provided.
2400	TOO03	Tooth surface	Enter the tooth surface for which the service was provided. Five surfaces can be indicated.
2400	DTP01	Date and time qualifier	Enter the value "472" for service date.

Loop	Element	Name	Instructions
2400	DTP02	Date time period format qualifier	Enter "D8" for format ccyymmdd.
2400	DTP03	Service date	Enter the date the procedure was performed.
2400	REF	Prior authorization or referral number	Enter the PA number in this segment. This number overrides any values submitted at the claim level. Note: Wisconsin Medicaid will use the first PA number submitted at the service line (loop 2400) to process the claim. Wisconsin Medicaid does not use referral numbers in the adjudication of claims.
2400	REF01	Reference identification qualifier	Enter the value "G1" for PA.
2400	REF02	Referral Number	Enter Wisconsin Medicaid's seven-digit PA number.
2400	REF	Line item control number	Enter the line item control number in this segment.
2400	REF01	Reference identification qualifier	Enter the value "6R" for provider control number.
2400	REF02	Line item control number	This field will be returned on the 835 Health Care Claim Payment/Advice. It should be used by providers if they need a way to uniquely match up service lines in their payment reconciliation process.
2420A	REF	Rendering provider secondary identification	Enter the rendering(performing) provider Medicaid identification number in this segment if the performing provider is Medicaid certified and different than the Wisconsin Medicaid billing provider.
2420A	REF01	Reference identification qualifier	Enter the value "1D" for Medicaid number.

Loop	Element	Name	Instructions
2420A	REF02	Rendering provider secondary Identifier	Enter the eight-digit provider number assigned by Wisconsin Medicaid.
2430	SVD01	Other payer primary identifier	Enter the other payer primary identifier if another payer has paid on the service line.
2430	SVD02	Service line paid amount	Enter the amount the other payer paid on the service line.
2430	CAS	Service adjustment	Include this segment when another payer has made payment at the service line. If the other payer returned an 835 remittance, the CAS segment from the 835 should be copied to this CAS. Note: Wisconsin Medicaid will use the information in the CAS segment in place of the "other insurance indicator" and "Medicare disclaimer code" submitted prior to HIPAA. If this iteration of loop 2430 contains information from a Medicare payer, Wisconsin Medicaid will also look for Medicare's coinsurance, copayment and deductible.
2430	DTP	Line adjudication date	Include this segment when another payer has made payment at the service line of this claim.
2430	DTP01	Date/time qualifier	Enter "573" for the claim paid date.
2430	DTP02	Date time period format qualifier	Enter "D8" for format ccyymmdd.
2430	DTP03	Adjudication or payment date	Enter the date the other payer paid the claim.